DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

#3 accepted

PRINTED: 11/10/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445145	A. BUILDING _____ B. WING _____	C 11/03/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - MOUNTAIN VIEW	1360 BYPASS ROAD WINCHESTER, TN 37398

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Investigation of C/O #26358, #26462, #26399 and #26709 was conducted September 27, 2010-November 3, 2010, at Golden Livingcenter-Mountain View. No deficient practice was cited for C/O #26358 and #26399. Deficient practice was cited at F157, F279 and F281 related to C/O #26709, and at F314 related to C/O #26462 and #26709.	F 000	Disclaimer Submission of this response and plan of correction is not a legal admission that deficiency exists or that this statement of deficiencies was correctly cited, and is also not to be construed as an admission of interest against the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation and submission of this plan of correction does not constitute an admission of agreement of any kind by the facility or the correctness of any conclusions set forth in this allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within (10) ten days of the survey as a condition to participate in Title 18 and Title 19 programs. The submission of the plan of correction within this time frame should in no way be considered or construed as agreement with the allegations of non-compliance or admissions by the facility. This plan of correction is submitted as the facility's credible allegation of compliance.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157	F157 Resident Resident #8 Physician has been notified and Order for treatment obtained by charge nurse on 9/22/10. Affected Residents New admissions to facility with wounds have the potential to be affected by this alleged deficient practice. Current residents admitted since Sept 27 2010 have been assessed for any skin issues by ADNS/Wound nurse/charge nurses on 11/21/10.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Pamela Reed — TITLE: Executive Director — (X6) DATE: 11-30-10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, observation and interview, the facility failed to notify the physician of a Pressure Ulcer and failed to obtain orders for treatment of the Pressure Ulcer for one (#8) of fifteen residents with Pressure Ulcers reviewed. The findings included: Resident #8 was admitted to the facility on September 9, 2010, with diagnoses including Anxiety, Urinary Tract Infection, Diabetes Mellitus, Lung Cancer and Hypertension. Medical record review of the "Clinical Health Status" (initial nursing assessment) dated September 9, 2010, revealed the resident had one Stage 3 Pressure Ulcer on the right buttock which measured "1 ½ " inches and was covered with a foam dressing and had an "unstageable" wound to the left heel. Medical record review of the Minimum Data Set dated September 16, 2010, revealed the resident had no short or long-term memory problems and was independent in decision-making skills; required extensive assistance with bed mobility, transfers, and activities of daily living; was incontinent of bowel and had an indwelling urinary catheter; had moderate pain daily; and had three stage 3 Pressure Ulcers. Medical record review of the physician's admission orders dated September 9, 2010, revealed no orders were obtained for wound	F 157	**System changes** Chart Audits will be conducted within 24 / 72 hours of new admission/readmission by DNS/Designee to verify physician notification of wounds. Nurse's notes, physician orders will be reviewed in morning meeting Monday through Friday to verify timely Notification of Physician. Nurses notes From weekend will be reviewed on Monday Morning by IDT. The IDT consist of DNS, ADNS, SSD,DCE, Dietary Manager and periodically by Executive Director. Education to nursing staff by DCE/DNS/ ADNS/Administrative Nurses on 11/10,11/11 and 11/22/10 on timely notification to Physician on admissions/readmissions identified skin issues. Education was provided to Current Active licensed nursing staff. This was validated by current roster. This education has been added To new hire education packet. **Monitoring** The 24 / 72 hour new admission/readmission chart reviews will be reviewed in morning meeting Monday through Friday by IDT to verify physician notification of any identified issues. The IDT consist of DNS, ADNS, SSD,DCE, Dietary Manager and periodically by Executive Director. 5 charts will be audited weekly for notification of skin concerns to Physician by ADNS/SSD weekly x4 and monthly x2 . Results of audits will be discussed in QA&A X 3 months. The meeting is attended by Executive Director, Director of Nursing (DNS), Assistant Director of Nursing (ADNS), Medical Director, Social Service, Activities, Dietary, Resident Assessment Coordinator and Maintenance Director and is held monthly.	11-24-10

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F 157	Continued From page 2 care/dressing changes on admission. Continued review of the admission physician's orders revealed, " ...May use low loss air mattress d/t (due to) Pressure Ulcer to coccyx ..." Medical record review of physicians' orders dated September 9-22, 2010, revealed orders for wound care were not obtained by the facility until September 22, 2010. Medical record review of a physician's order dated September 22, 2010, revealed, "clean open areas to rt (right) buttock with wound cleanser(.) apply tenderwet cover with combiderm(.) change qd (every day) and prn (as needed) until healed." Medical record review of a physician's order dated September 22, 2010, revealed, "cleanse red areas to lt (left) buttock with wound cleanser and apply Duoderm(.) change q (every) 3 days and prn until healed." Review of the facility's policy for "Skin Care Management" revealed, " ...Pressure Ulcer Flow Diagram ...Pressure Ulcer identified from admission skin assessment/weekly skin assessment observation ...Notify physician and document notification ...Input MD (Medical Doctor) order/treatment ...Print new treatment order and place on Treatment Administration Record (TAR) ..." Medical record review of nurse's notes revealed a Duoderm dressing was applied to the buttock on September 21, 2010, and with no physician's order for the Duoderm. Observation on September 27, 2010, at 4:30 p.m., with the Director of Nursing (DON) and Licensed Practical Nurse #1 revealed the resident had three wounds on the right buttocks which were measured by the DON as follows: one stage 3 measured 3.0 cm (centimeters) x (times) 2.0	F 157		

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F 157	Continued From page 3 cm; one stage 2 measured 1.0 cm x 1.5 cm, both described with "yellow slough;" and one stage 2, measured 0.3 cm x 0.3 cm. Continued observation with the DON and LPN #1 revealed an unstageable wound to the left heel which was measured by the DON as 2.5 cm x 3.0 cm and a "new" unstageable wound at the base of the right "little toe" which measured 0.3 cm x 0.3 cm. Medical record review and interview on October 5, 2010, at 1:00 p.m., in the conference room, with the Treatment Nurse (RN #2), who was providing wound care in the facility in the month of September 2010, revealed the Treatment Nurse "never knew about ...wounds" and confirmed the Treatment Nurse did not notify the physician to obtain treatment orders for the Pressure Ulcers which were present on admission or which developed after admission to the facility. Medical record review and interview on October 6, 2010, at 8:40 a.m., in the conference room, with the DON confirmed the only dressing change which was documented from the date of admission until September 21, 2010, was Duoderm which was applied on September 21, 2010. Continued medical record review and interview with the DON on October 6, 2010, at 8:40 a.m., confirmed the resident had one stage 3 pressure ulcer on admission on September 9, 2010, and on September 21, 2010, the resident had a stage 3 and two stage 2 Pressure Ulcers to the right buttock. Continued interview with the DON confirmed the facility failed to notify the physician of the wounds which were present on admission and failed to secure orders for treatment to the wounds from September 9, 2010, until September 22, 2010. C/O #26709	F 157		

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F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, observation and interview, the facility failed to update the care plan to include wounds and interventions to promote healing of the wounds for four (#3, #9, #13, #14) of sixteen residents reviewed. The findings included: Resident #3 was admitted to the facility on May 14, 1999, with diagnoses including Hypertension, Peripheral Vascular Disease, Delusion, Psychosis, Diabetes Mellitus and Depressive	F 279	F279 **Resident** Residents #3,#9,#13,#14 care plans have been reviewed by DNS/Wound Nurse / MDS nurse and updated to reflect current resident Care needs and interventions as needed on 11/15/10. **Affected Residents** Residents with wounds have the potential to Be affected by alleged deficient practice. Residents current wound care plans have been audited and updated As needed to reflect current care needs and interventions by DNS/Wound Nurse/MDS nurse on 11/15/10 **System changes** Care plans of residents with new wound orders or new wounds will be reviewed by DNS/MDS nurse/Wound Nurse in morning meeting Monday through Friday to verify updates. Education to licensed nursing staff by DCE/DNS/ADNS/Administrative Nurses on 11/10,11/11 and 11/22/10 related to updating care plans with residents with new wounds, interventions and treatments have been completed. Education was provided to Current Active licensed nursing staff . This was validated by current roster. This education has been added to new hire education packet.	

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F 279	Continued From page 5 Disorder. Medical record review of the Minimum Data Set (MDS) dated June 18, 2010, revealed the resident had short and long-term memory problems and moderately impaired decision-making skills and was totally dependent of staff for all activities of daily living. Medical record review of a physician's order dated June 27, 2010, revealed, "Two times a day apply skin prep to Right toes until resolved two times per day." Medical record review of a physician's order dated September 17, 2010, revealed, "Clean rt (right) heel with ns (normal saline) and apply skin prep daily bid." Medical record review of the current care plan revealed the care plan included the resident's " ...risk for Pressure Ulcers and altered skin integrity ..." with the goal of " ...will have no loss of skin integrity ..." Continued review of the current care plan revealed the care plan had not been updated to reflect the unstageable wound to the right heel and the intervention to "float" the heel from the bed to relieve pressure on the heel. Observation and interview on September 27, 2010, at 3:45 p.m., with the Director of Nursing (DON) revealed the resident's right leg was lying on a pillow with the right heel lying on the bed. Observation revealed black necrosis to the right heel measured by the DON as 4.0 cm (centimeters) x (by) 5.0 cm and described by the DON as unstageable. Continued observation with the DON revealed a wound to the right great toe which was measured by the DON as 4.0 cm x 4.0 cm. Interview with the DON at the time of the observation confirmed the right heel was resting on the bed and was not "floated" to relieve pressure on the heel.	F 279	**Monitoring** DNS/ADNS will audit 5 residents with wound care plans weekly x 4 and monthly x 2 to verify appropriate updates. Results of audits will be discussed in QA&A X 3 months. The meeting is attended by Executive Director, Director of Nursing (DNS), Assistant Director of Nursing (ADNS), Medical Director, Social Service, Activities, Dietary, Resident Assessment Coordinator and Maintenance Director and is held monthly	11-24-10

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F 279	Continued From page 6 Medical record review and interview on October 5, 2010, at 7:25 a.m., with the MDS Coordinator confirmed the current care plan addressed prevention of loss of skin integrity and had not been updated to include the unstageable wound to the right heel and the intervention to "float" the heel from the bed to relieve pressure on the heel. Resident #9 was admitted to the facility on June 29, 2010, with diagnoses including Paraplegia, Alzheimer's Disease, Chronic Kidney Disease, Hypertension. Chronic Obstructive Pulmonary Disease, Degenerative Disk Disease and Decubitus Ulcer. Review of the "Clinical Health Status" (initial nursing assessment) dated June 29, 2010, revealed the resident had a Pressure Ulcer on the coccyx which measured 11.0 cm x 9.0 cm x 4.0 cm with tunneling of 8.0 cm. Medical record review of the care plan dated June 30, 2010, revealed the care plan did not address the stage 4 Pressure Ulcer to the coccyx and did not include interventions related to treatment of the Pressure Ulcer. Telephone interview and review of the care plan on October 21, 2010, with the MDS Coordinator confirmed the care plan did not address the stage 4 Pressure Ulcer to the coccyx and did not include interventions related to treatment of the Pressure Ulcer. Resident #13 was readmitted to the facility on September 10, 2010, with diagnoses including Pressure Ulcer, Urinary Obstruction, Epilepsy and Recurrent Seizures, Congestive Heart Failure, Diabetes Mellitus, Anemia, Paranoid Schizophrenia and Hypertension. Medical record	F 279		

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F 279	Continued From page 7 review of the MDS dated September 17, 2010, revealed the resident had short and long-term memory problems and moderately impaired decision-making skills; was totally dependent on staff for activities of daily living; and had one stage 2 Pressure Ulcer. Medical record review of the current care plan revealed the care plan included the resident's "potential for altered skin integrity" with the goal of " ...will have no loss of skin integrity ..." Continued review of the current care plan revealed no interventions were included related to the stage 2 Pressure Ulcer. Medical record review of the facility's skin care management policy revealed, " ...The interdisciplinary plan of care will address problems, goals and interventions directed toward prevention of Pressure Ulcers and/or skin integrity concerns identified ...Determine care plans consistently ...revised based on the needs of the resident ..." Medical record review and interview on October 5, 2010, at 7:20 a.m., with the MDS Coordinator confirmed the current care plan addressed prevention of loss of skin integrity and had not been updated to include the stage 2 Pressure Ulcer and interventions to promote healing. Resident #14 was admitted to the facility on November 13, 2008, with diagnoses including Alzheimer's Disease, Dementia with Behavioral Disturbances, Dehydration, Psychosis, Seizures and Benign Prostatic Hypertrophy. Medical record review of the Minimum Data Set dated July 3, 2010, revealed the resident had short and long-term memory problems and severely	F 279		

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F 279	Continued From page 8 impaired decision-making skills; was totally dependent on staff for all activities of daily living; and had no pressure ulcers. Medical record review of the "Clinical Health Status" dated October 5, 2010, revealed the resident had no wounds except to the left ankle. Medical record review of a nurse's note dated October 25, 2010, revealed, "Open area note to crease of right ear with bloody drainage noted; resident grimaces when area is touched. Tx (treatment) nurse aware & (and) area cleaned with NS (normal saline), bactracin (Bacitracin) ointment applied, gauze in place to keep tubing off area..." Review of the facility's weekly Pressure Ulcer report dated October 26, 2010, revealed the resident had a Stage 2 Pressure Ulcer to the right posterior ear which measured 1.6 cm x 0.2 cm. Medical record review of a nurse's note by RN #4/Treatment Nurse revealed, "raw area to rt (right) ear 1.6 (cm) x 0.2 (cm), cleaned with normal saline and applied oxy ears (foam padding around oxygen tubing) to O2 (oxygen) for preventive measures." Medical record review of the "Wound Evaluation Flow Sheet" dated October 26, 2010, revealed the Stage 2 Pressure Ulcer to the right posterior ear measured 1.6 cm x 0.2 cm. Medical record review and interview, in the conference room, on November 2, 2010, at 12:00 p.m., with the RN/Treatment Nurse #4 confirmed the care plan had not been updated to include the Stage 2 Pressure Ulcer and interventions to reduce the risk of the development of a Pressure Ulcer from the pressure of oxygen tubing on the	F 279		

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F 279	Continued From page 9 ears. C/O #26709	F 279		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, the facility failed to assess the surgical wounds and injuries for one (#2) and failed to implement the care plan for one (#3) of sixteen residents reviewed. The findings included: Resident #2 who was involved in a high-speed motorcycle crash, was admitted to the facility on June 10, 2010, with diagnoses including Fracture of the Left Arm and Shoulder with Open Reduction Internal Fixation, Fracture of the Left Wrist, Left knee, Left Tibia and Fibula, MRSA (methicillin-resistent Staphylococcus aureus), Psychosis and Bipolar Disorder. Medical record review of the Minimum Data Set dated June 18, 2010, revealed the resident had no short or long-term memory problems and was independent in decision-making; had no behavioral symptoms or indicators of Depression, Anxiety or sad mood; required limited assistance with bed mobility, transfers, dressing, toileting and hygiene and was continent of bladder and bowel. Medical record review of a physician's order dated July 5, 2010, revealed, "Cleanse surgical	F 281	F281 **Residents** Resident # 2 has been discharged from facility. Resident # 3 has been assessed for current wound status by DNS/Wound nurse on 11/16/10 and appropriate interventions are in place which include by not limited to- weekly skin inspection ,pressure reducing/relieving mattress, treatment as ordered by MD, Nutritional support as needed, pressure reducing cushion, Barrier cream, positioning –floating of heels and turning , monitor for signs of infection. **Affected Residents** Newly admitted residents with wounds and residents currently residing in the facility with wounds have the potential to be Affected by this alleged deficient practice. Current residents with pressure ,arterial, stasis and surgical wounds have been assessed for appropriate treatment and Interventions by DNS/Wound Nurse on 11/23/10. **System changes** Weekly skin inspections conducted By charge nurses will be brought to morning meeting and reviewed on an ongoing basis by IDT the IDT consist of DNS,ADNS, SSD, DCE, Dietary Manager and periodically by Executive Director. The morning meeting is conducted Mon through Fri.	

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F 281	Continued From page 10 wound left lower leg with wound cleanser and 4x(by)4's, apply Triple Antibiotic Ointment to wound, cover with gauze, secure with Kerlex and tape ...every shift ..." Medical record review of the "Clinical Health Status" (initial nursing assessment) dated June 11, 2010, revealed no assessment of the resident's skin condition. Medical record review and interview on October 5, 2010, at 1:00 p.m., in the conference room, with Registered Nurse (RN #2)/Treatment Nurse confirmed the resident had surgical and trauma wounds on admission and confirmed the initial nursing assessment dated June 11, 2010, did not include any skin assessment or assessment of the resident's wounds. Resident #3 was admitted to the facility on May 14, 1999, with diagnoses including Hypertension, Peripheral Vascular Disease, Delusion, Psychosis, Diabetes Mellitus and Depressive Disorder. Medical record review of the Minimum Data Set dated June 18, 2010, revealed the resident had short and long-term memory problems and moderately impaired decision-making skills and was totally dependent of staff for all activities of daily living. Medical record review of the current care plan revealed, " ...Resident to use a heel boot to right heel." Review of the facility's policy for "Skin Care Management" revealed, " ...Determine care plans consistently implemented ...based on the needs of the resident ..." Observation and interview on September 27, 2010, at 3:45 p.m., with the Director of Nursing	F 281	The 24 / 72 hour new admission /readmission chart reviews will be reviewed in morning meeting Mon through Fri by the IDT to verify completion of skin evaluation on admission. The IDT consist of DNS, ADNS, SSD,DCE, Dietary Manager and periodically by Executive Director. DNS / ADNS/Supervisor will conduct a second skin evaluation on new Admissions within 24 hours of admission. DNS/ADNS are conducting weekly wound Rounds on current residents with current Pressure, arterial, stasis or surgical wounds to verify treatments, evaluations and intervention in place. These rounds will be ongoing . Non clinical rounds are conducted 3 x a week by the administrative team which include ADNS,BOM, Medical records, Activities director and assistant, Maintenance, Dining services Director, Social Services,Central supply clerk, marketing, receptionist, Human resources, MDS nurses , DNS, Director of Clinical Services These round will check wound interventions for 5 random residents 3 x weekly x 4 weeks and monthly x 2. Cardexes are used for direct care staff to know current interventions. Education to licensed nursing staff by DCE/DNS/ADNS/Administrative Nurses on 11/10, 11/11 and 11/22/10 on completing skin evaluations on Admission and as needed has been completed Education to Nursing staff on use of indentified interventions to Include heel protectors has been completed. Education was provided to Current Active licensed nursing staff .This was validated by current roster. This education has been added To new hire education packet.	

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F 281	Continued From page 11 (DON) revealed the resident's right leg was lying on a pillow with the right heel lying on the bed. Continued observation revealed a heel protector was not in place to the right heel. Observation revealed black necrosis to the right heel measured by the DON as 4.0 cm (centimeters) x (by) 5.0 cm and described by the DON as unstageable. Continued observation with the DON revealed a wound to the right great toe which was measured by the DON as 4.0 cm x 4.0 cm. Interview with the DON at the time of the observation confirmed a heel boot was not in place on the right heel. C/O #26709	F 281	**Monitoring** Results of audits will be discussed in QA&A X 3 months. The meeting is attended by Executive Director, Director of Nursing (DNS), Assistant Director of Nursing (ADNS), Medical Director, Social Service, Activities, Dietary, Resident Assessment Coordinator and Maintenance Director and is held monthly	11-24-10
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility policies, observation and interview, the facility failed to accurately assess and provide dressing change as ordered by the physician for one (#7); failed to obtain physician's orders for treatment and failed to assess Pressures Ulcers for one (#8); and failed to pad oxygen tubing to prevent a Pressure Ulcer for one (#14) of fifteen residents with Pressure Ulcers reviewed.	F 314	F314 **Resident** Resident #7 has been discharge from facility Resident # 8 Physician was notified and Order for treatment obtained by charge nurse on 9/22/10 Res 8 no longer resides In facility . Resident # 14 has appropriate padding for O2 tubing. **Affected residents** Residents at risk to develop wounds have potential To be affected by this alleged deficient practice. Skin audits were conducted by charge nurses on 11/21/10 on residents currently residing in facility and reviewed by DNS/ADNS and identified skin concerns were addressed according to protocol	

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F 314	Continued From page 12 The findings included: Resident #7 was admitted to the facility on July 8, 2010, for a five-day hospice respite stay, with diagnoses including Alzheimer's Disease, Failure to Thrive and Pressure Ulcer. Medical record review of the physician's recapitulation orders dated July 8-31, 2010, revealed, " ...Change hydrocolloid dsg (dressing) every 3 days or if soiled cleanse with saline, pat dry with gauze sponges then apply dressing ..." Medical record review of a nurse's note dated July 8, 2010, at 7:07 p.m., revealed, " ...Resident came with orders for wound care: Change hydrocolloid dressing to right lower sacral areas every 3 days and prn ..." Medical record review of the Treatment Record dated July 8-31, 2010, revealed no documentation wound care was provided July 8-13, 2010, (date of discharge). Review of the facility's "Skin Care Management" policy and "Pressure Ulcer Flow Diagram" revealed, " ...Implement resident specific interventions immediately: ...Treatment as ordered ..." Interview on September 29, 2010, at 9:05 a.m., in the conference room, with Registered Nurse (RN) #1, (assigned to the unit where the resident resided) revealed the RN was "unaware" the resident had a dressing and stated, "No one told me (resident) had a place that needed attention." Continued interview with the RN confirmed the Duoderm dressing was not changed during the resident's stay in the facility from July 8-13, 2010, as ordered by the physician.	F 314	System changes Weekly skin inspections conducted By charge nurses will be brought to morning meeting and reviewed by IDT This is ongoing. The IDT consist of DNS, ADNS, SSD,DCE, Dietary Manager and periodically by Executive Director. Morning meeting is conducted Mon through Fri. DNS /ADNS/supervisor will do second skin evaluation on new Admissions within 24 hours of admission. This will be ongoing. DNS/ADNS are conducting weekly wound Rounds on current residents with current Pressure ,arterial, stasis or surgical wounds to verify treatments, evaluations and intervention in place. These rounds will be ongoing. ED/DNS redistributed and clarified the wound nurse and charge nurse Duties in identifying ,treatment and Monitoring of skin care. When wound is Identified charge nurse on duty is responsible to notify Dr and get treatment started. Wound nurse will monitor , assist with treatments relating to pressure wounds,arterial,stasis,and surgical and measurements.Other treatments are responsibility of charge nurses. The 24-72 hour new admission/readmission Chart reviews will be reviewed in morning meeting Mon through Fri by IDT to verify completion of skin evaluation on admission and review clinical health assessment to verify resident identified at risk will have appropriate interventions in place . The IDT consist of DNS, ADNS, SSD,DCE, Dietary Manager and periodically by Executive Director.	

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F 314	Continued From page 13 Interview on September 29, 2010, at 12:20 p.m., in the conference room, with the Director of Nursing (DON) confirmed the dressing to the Pressure Ulcer was not changed during the resident's five-day stay in the facility from July 8-13, 2010. Medical record review of the "Clinical Health Status" dated July 8, 2010, revealed no documentation the Pressure Ulcer on the sacrum was assessed for location, size, stage, drainage, surrounding tissue nature of the wound. Medical record review revealed no documentation the Pressure Ulcer was assessed during the resident's five-day stay in the facility from July 8-13, 2010. Review of the facility's "Skin Care Management" and "Risk Identification/Prevention" policy revealed, " ...All residents will be assessed/observed for risk of skin breakdown within 24 hours of admission...Pressure Ulcer identified from admission skin assessment ...document initial assessment of pressure area including: Location and staging(,) Size(,) Exudate (drainage)/ if present: type, color, odor, and approximate amounts(,) Pain/if present: nature and frequency(,) Wound bed: color & (and) type of tissue/character including evidence of healing (granulation) or necrosis (slough and exchar)(,) Description of (wound) edges and surrounding tissue ..." Medical record review and interview on October 5, 2010, at 10:25 a.m., in the conference room, with the DON confirmed the facility's policy was not followed, and the Pressure Ulcer was not assessed on admission or at any time during the	F 314	Education to licensed nursing staff by DCE/DNS/ADNS/Administrative Nurses on 11/10,11/11 and 11/22/10 on skin care management guideline which includes identification of skin concerns and Interventions. .Weekly skin inspection and documentation requirements were included in the education. This was validated by current roster.This education has been added to new hire education packet. **Monitoring** Results of audits will be discussed in QA&A X 3 months. The meeting is attended by Executive Director, Director of Nursing (DNS), Assistant Director of Nursing (ADNS), Medical Director, Social Service, Activities, Dietary, Resident Assessment Coordinator and Maintenance Director and is held monthly,	11-24-10

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F 314	Continued From page 14 resident's five day stay in the facility from July 8-13, 2010. Resident #8 was admitted to the facility on September 9, 2010, with diagnoses including Anxiety, Urinary Tract Infection, Diabetes Mellitus, Lung Cancer and Hypertension. Medical record review of the Minimum Data Set (MDS) dated September 16, 2010, revealed the resident had no short or long-term memory problems and was independent in decision-making skills; required extensive assistance with bed mobility, transfers, and activities of daily living; was incontinent of bowel and had an indwelling urinary catheter; and had three stage 3 Pressure Ulcers. Medical record review of the "Clinical Health Status" (initial nursing assessment) dated September 9, 2010, revealed the resident was at moderate risk for Pressure Ulcers; had a Stage 3 Pressure Ulcer on the left buttock which measured "1 ½ " inches (one inch equals 2.5 centimeters) and was covered with a foam dressing; and had an "unstageable" wound to the left heel (no measurements documented). Continued review revealed no documentation of the size or nature of the unstageable wound on the left heel. Review of the weekly skin report for Pressure Ulcers revealed the wounds were not assessed again until September 21, 2010 (twelve days later). Medical record review of the weekly Pressure Ulcer report dated September 21, 2010, revealed the resident had a Stage 2 Pressure Ulcer on the right buttock measuring 1.0 cm (centimeters) x (by) 1.5 cm, a Stage 2 Pressure Ulcer on the right buttock measuring 0.5 cm x 1.3 cm, a Stage 3 pressure on the right buttock	F 314		

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F 314	Continued From page 15 measuring 3.0 cm x 2.0 cm and a Stage 1 Pressure Ulcer to the left buttock (no measurement documented). Medical record review of a "Wound Evaluation Flow Sheet" dated September 22, 2010, revealed the resident had an unstageable Pressure Ulcer to the left heel measuring 3.0 cm x 3.0 cm. Review of the facility's "Skin Care Management" policy revealed, " ...Purpose: to provide a systemic approach and monitoring process for skin ...All residents will be assessed/observed for risk of skin breakdown within 24 hours of admission ...(facility) develops a routine to review residents with wounds or at risk on a weekly basis ...Wound status is monitored on a weekly basis ...Documentation of Weekly Skin Assessments/Observations: Licensed nurse will be responsible for performing this skin assessment/observation ...Licensed nurse to document weekly on all wounds using the "Wound Evaluation Flow Sheet ...document...Location and staging...Size (length x width/depth) presence and location of undermining and tunneling...Exudate/if present: nature and frequency...Wound bed: color & (and) type of tissue/character including evidence of healing (granulation) or necrosis (slough and eschar)...Description of (wound) edges and surrounding tissue..." Medical record review, review of the weekly skin reports for Pressure Ulcers and interview on October 6, 2010, at 8:40 a.m., in the conference room, with the DON confirmed the Pressure Ulcers had not been assessed between September 9, 2010, and September 21, 2010. Continued interview confirmed on September 9, 2010, the resident had one stage 3 Pressure	F 314		

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F 314	Continued From page 16 Ulcer on the left buttock, and on September 21, 2010, the resident had two stage 2 and one stage 3 on the right buttock and a stage 1 Pressure Ulcer on the left buttock. Continued interview confirmed the pressure ulcers were not assessed the week of September 13, 2010, and confirmed the facility's policy to perform weekly Pressure Ulcer assessments had not been followed. Medical record review of the physician's admission orders dated September 9, 2010, revealed no orders were obtained for wound care/dressing changes on admission. Continued review of the admission physician's orders revealed, " ...May use low loss air mattress d/t (due to) Pressure Ulcer to coccyx ..." Continued review of physicians' orders dated September 9-21, 2010, revealed no orders for wound care were obtained by the facility. Medical record review of a physician's order dated September 22, 2010, revealed, "clean open areas to rt (right) buttock with wound cleanser(.) apply tenderwet cover with combiderm(.) change qd (every day) and prn (as needed) until healed." Medical record review of another physician's order dated September 22, 2010, revealed, "cleanse red areas to lt (left) buttock with wound cleanser and apply Duoderm(.) change q (every) 3 days and prn until healed." Medical record review of the Treatment Record dated September 2010, and nursing notes dated September 9-22, 2010, revealed wound care was not provided from September 9-21, 2010. Medical record review of nurses' notes dated September 9-22, 2010, revealed no documentation wound care had been provided from September 9-20, 2010, and revealed a Duoderm dressing was applied to the buttock on	F 314		

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F 314	Continued From page 17 September 21, 2010 (twelve days after admission). Observation and interview on September 27, 2010, at 4:30 p.m., with the DON and the Licensed Practical Nurse (LPN) #1 revealed the resident lying in bed on a low air-loss mattress. Continued observation with the DON and LPN #1 revealed the resident had Pressure Ulcers on the right buttocks, described by the DON as: one stage 3, 3.0 cm x 2.0 cm and one stage 2, 1.0 cm x 1.5 cm, both with "yellow slough" and one stage 2, 0.3 cm x 0.3 cm. The DON described an unstageable wound to the left heel, 2.5 cm x 3.0 cm with the margins intact and a "new" unstageable wound to the base of the right "little toe" which measured 0.3 cm x 0.3 cm. Medical record review and interview on October 5, 2010, at 1:00 p.m., in the conference room, with RN #2/Treatment Nurse, who was providing wound care in the facility, in the month of September 2010, confirmed the Treatment Nurse had no knowledge of the resident's wounds; did not provide wound care for the resident; and did not notify the physician to obtain treatment orders for the Pressure Ulcers. Medical record review and interview on October 6, 2010, at 8:40 a.m., in the conference room, with the DON confirmed wound care was not provided from September 9-20, 2010, and confirmed the facility failed to obtain physician's orders for treatment to the wounds from September 9, 2010, until September 22, 2010. Resident #14 was admitted to the facility on November 13, 2008, with diagnoses including Alzheimer's Disease, Dementia with Behavioral	F 314		

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F 314	Continued From page 18 Disturbances, Dehydration, Psychosis, Seizures and Benign Prostatic Hypertrophy. Medical record review of the Minimum Data Set dated July 3, 2010, revealed the resident had short and long-term memory problems and severely impaired decision-making skills; was totally dependent on staff for all activities of daily living; and had no pressure ulcers. Medical record review of the "Clinical Health Status" dated October 5, 2010, revealed the resident had no Pressure Ulcers. Medical record review of the physician's orders dated November 1, 2010, revealed, "...O2 (Oxygen) at 2 lpm (liters per minute) to maintain O2 sats (saturation level) above 90 % (percent)..." Medical record review of a nurse's note dated October 25, 2010, at 2:57 p.m., revealed, "Open area noted to crease of right ear with bloody drainage noted; resident grimaces when area is touched. Tx (treatment) nurse aware & (and) area cleaned with NS (normal saline), bactracin (Bacitracin) ointment applied, gauze in place to keep tubing off area..." Medical record review of a nurse's note dated October 25, 2010, at 3:45 p.m., revealed, " ...CNA noted an open area behind residents ear while shaving ...Area appears to be caused from O2 tubing ..." Review of the facility's weekly Pressure Ulcer report dated October 26, 2010, revealed the resident had a Stage 2 Pressure Ulcer to the right posterior ear which measured 1.6 cm x 0.2 cm. Medical record review of a nurse's note by RN #4/Treatment Nurse dated October 26, 2010, revealed, "raw area to rt (right) ear 1.6 (cm) x 0.2 (cm), cleaned with normal saline and applied Oxy	F 314		

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F 314	Continued From page 19 Ears (foam padding around O2 tubing) to O2 tubing for preventive measures." Medical record review of the "Wound Evaluation Flow Sheet" dated October 26, 2010, revealed the Stage 2 Pressure Ulcer to the right posterior ear measured 1.6 cm x 0.2 cm. Medical record review of the "Wound Evaluation Flow Sheet" dated October 29, 2010, revealed the Stage 2 Pressure Ulcer to the right posterior ear had healed. Interview on November 2, 2010, at 11:30 a.m., in the conference room, with the RN/Treatment Nurse #4 confirmed the resident had a painful Stage 2 Pressure Ulcer "caused by oxygen tubing." Continued interview with RN#4/Treatment Nurse revealed Oxy Ears (foam padding around oxygen tubing) were placed on the oxygen tubing over both ears to promote healing. Continued interview with RN #4/Treatment Nurse revealed the Pressure Ulcer to the right posterior ear was healed as of October 29, 2010. Observation and interview on November 2, 2010, at 11:40 a.m., with RN #4/Treatment Nurse revealed the resident was lying in bed with oxygen tubing in place around both ears, and Oxy Ears were not in place. Continued observation and interview with RN #4/Treatment Nurse confirmed the Oxy Ears were not in place and confirmed the resident had a new Stage 2 Pressure Ulcer to the right posterior ear which was red and moist but with no drainage and measured by the Treatment Nurse as 0.5 cm x 0.5 cm. Continued interview with the Treatment Nurse confirmed the Treatment Nurse would reapply Oxy Ears to the O2 tubing.	F 314		

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F 314	Continued From page 20 C/O #26462, #26709	F 314		